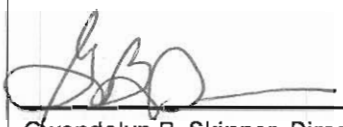
Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	POLICY NO: 2.101
Applicability: • State Hospitals • Public and Private community providers • OTP & State-operated community programs • State MHDDAD office • Regional MHDDAD offices	REFERENCE: Official Code of Georgia 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166; 37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1 et seq.; 19-7-5; 16-6-5.1; DHR Rules and Regulations for Patients' Rights, Chapters 290-4-6; DHR Rules and Regulations for Clients' Rights 290-4-9.
SUBJECT: **Reporting of Consumer Deaths and Critical Incidents**	**Effective date: October 1, 2006** **Scheduled Review Date:**
Attachments: A-Critical Incident Definitions & Reporting Requirements B-Critical Incident Report form C-Reporting to other Agencies	APPROVED:  **Gwendolyn B. Skinner, Director MHDDAD**

I. POLICY

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) to maintain a safe and humane environment for consumers, and to prevent abuse, neglect and exploitation of consumers. The DMHDDAD uses a standardized process for reporting and investigating deaths and critical incidents that involve consumers being served by the DMHDDAD in state hospitals and community providers. The process also includes procedures for consumers who are participating in waiver program consumer directed services.

II. DEFINITIONS

Category I Incidents

- Unexplained Death (including suicides)
- (Allegation of) Physical abuse
- (Allegation of) Neglect
- (Allegation of) Staff to consumer sexual assault or sexual exploitation
- (Allegation of) Consumer to consumer sexual assault or sexual exploitation
- Medication errors with adverse consequences
- Seclusion or restraint resulting in injury requiring treatment beyond first aid
- Suicide attempt that results in medical hospitalization

Category II Incidents

- Death (other than unexplained)
- (Allegation of) Verbal abuse

- (Allegation of) Financial exploitation
- Consumer who leaves the grounds of a state hospital without permission
- Consumer who is unexpectedly absent from a community residential program
- Seclusion or restraint resulting in injury requiring minor first aid
- Vehicular accident with injury while consumer is in a state vehicle or is being transported by community or hospital staff
- Incident occurring at a provider's site which required intervention of law enforcement services
- Criminal conduct by consumer
- Consumer to consumer assault resulting in injury requiring treatment beyond first aid
- Consumer to consumer assault with injury requiring minor first aid
- Medical hospitalization of a consumer of a state hospital (including state operated community programs) or community residential program
- Consumer injury requiring treatment beyond first aid

See Attachment A for definitions of incidents.

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by the DMHDDAD and/or providing Medicaid services authorized by DMHDDAD. "Community Provider" includes any state owned or operated community program. For purposes of this policy, community provider includes services provided through a subcontractor.

Community Residential Consumer: A consumer receiving MHDDAD services in a home that is staffed by a provider organization and/or a consumer receiving personal support 24 hours/7 days a week.

Consumer: An individual enrolled with a community provider for disability services, seeking services or admission at a state hospital, or on the census of a state hospital or state operated community program.

Consumer-Directed Services: A model for service delivery in which consumers have the option to control and direct Medicaid funds identified in an individual budget, and in which the consumers live in their own homes. The consumer hires and fires direct support staff, and works with a support coordinator/support broker to receive assistance needed with self-directing services.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any consumer in community residential services, on site with a community provider or hospital, in the company of a staff member of a community provider or hospital, absent without leave from inpatient or residential

services, or enrolled in consumer-directed services. Critical incidents include, but are not limited to, all incidents as listed in categories I and II.

Critical Incident Database: DMHDDAD web-based system for entering data about critical incidents.

Disability Services: Direct services to an individual, or services, which are designed to prevent or ameliorate the effect of a disability.

High-Visibility Incident: Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DHR or DMHDDAD, or may have significant impact upon, or significant relevance to, issues of DHR or DMHDDAD public concern and/or are likely to be reported in the media.

Senior Executive Manager: The supervisor administratively in charge at the time of the incident.

State Hospital: A state Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) hospital facility.

Support Coordinator: In DMHDDAD developmental disability services, the independent case manager for each consumer.

Support Coordinator/Support Broker: In consumer-directed services, the specific support coordinator who has responsibility for working with the consumer and the consumer's support system as a team to assist the consumer to manage his or her direct support needs and budgeting. The support coordinator/support broker has responsibility for ensuring reporting of critical incidents.

Support System: In consumer-directed services, the consumer's support system includes direct support workers, family, friends and neighbors. The support coordinator/support broker has responsibility for receiving information from the support system about critical incidents as they occur.

III. PROCEDURES

A. Reporting deaths

1. Upon discovery of the death of a consumer, the state hospitals/community providers or support coordinators/support brokers

immediately take any actions necessary to protect other consumers' health, safety and rights. These actions may include:

- Immediate and ongoing medical attention, as appropriate;
- Suspension or reassignment of an employee from a position involving direct care pending the outcome of any investigation; and
- Other measures to protect the health, safety and rights of other consumers, as necessary.

2. Upon discovery of the death of a consumer, the:

   - Community provider or support coordinator/support broker immediately calls local law enforcement and the coroner/medical examiner if law enforcement has not called the coroner/medical examiner;
   - State hospital calls law enforcement if the death is unexplained;
   - State hospital/community provider or support coordinator/support broker calls the guardian, if any, and/or next of kin of the deceased after authorization from the coroner/medical examiner;
   - State hospital/community provider notifies the support coordinator, if applicable, within 24 hours; and
   - State hospital/community provider or support coordinator/support broker in instances when DFACS, DJJ, or APS has custodial or commitment responsibility, notifies the worker within 24 hours.

3. In the case of a child's death in a state hospital or state operated community program, the state hospital/community provider or designates a staff person, who is qualified to provide crisis/grief counseling, to notify the parent/guardian in person of the death.

4. The Regional Hospital Administrator immediately reports the unexplained death of any state hospital consumer to the DMHDDAD Division Director by telephone.

5. The state hospital/community provider or support coordinator/support broker immediately reports all unexplained deaths to the Investigations Section by telephone. These calls must be made as soon as possible, but at least within two (2) hours of the death. The provider should present any information available at the time of the telephone report that is required on the *Critical Incident Report* form (Attachment B). A copy of the *Critical Incident Report* form must be submitted electronically on the same day as the consumer's death, or on the next business day if the death occurred after business hours or on a

weekend or holiday. The senior executive manager is responsible for ensuring that both the telephone notification and the written *Critical Incident Report* are submitted as required.

6. The Investigations Section notifies the Medical Director and Regional Coordinator of unexplained deaths by the next business day. The Investigations Section also notifies the Division Director of unexplained deaths of consumers of community providers on the next business day.

7. If a decision is made that it is necessary to contact the Georgia Bureau of Investigation (GBI) regarding possible commission of a crime, the Investigations Section consults with the Division Director prior to contacting the GBI.

8. For all other consumer deaths, the state hospital/community provider submits the *Critical Incident Report* form (Attachment B) to the Investigations Section electronically. The report must be submitted on the same day as the consumer's death or on the next business day if the death occurred after business hours or on a weekend or holiday.

9. The DMHDDAD Medical Director serves as consultant to the Investigations Section as needed.

10. The state hospital/community provider requests that the coroner/medical examiner conduct an autopsy and provides sufficient facts to the coroner/medical examiner regarding the death.

11. In the event that the coroner/medical examiner decides not to perform an autopsy, the state hospital/community provider ensures that the coroner/medical examiner's decision is documented, and if known, the rationale for the decision.

12. For consumer deaths that must be reported to other agencies or offices as required by law or regulation, the state hospital/community provider or support coordinator/support broker is responsible at all times for notifying such agencies and offices in a timely manner. (See Attachment C)

13. The Investigations Section obtains a copy of the death certificate from the Division of Public Health. This copy will not be reproduced or released outside the Division of MHDDAD.

B. Reporting all other Category I and II Critical Incidents (excluding deaths)

1. Upon discovery of a critical incident other than a death, state hospitals/community providers or support coordinator/support brokers immediately take any action necessary to protect consumers' health, safety and rights. These actions may include:

   - Contacting 911 or other emergency services as needed;
   - Immediate and ongoing medical attention, as appropriate;
   - Removal of an employee from direct contact when the employee is alleged to have been involved in physical abuse, neglect, sexual abuse or sexual exploitation until such time as the state hospital/community provider has sufficiently determined that such removal is no longer necessary; and
   - Other measures to protect the health, safety and rights of the individual, as necessary.

2. The state hospital/community provider or support coordinator/support broker immediately calls:

   - Local law enforcement and the Investigations Section if there is reasonable suspicion that a crime has been committed; and
   - The consumer's guardian and/or next of kin, as appropriate with respect to confidentiality regulations.

3. If a decision has been made to contact the Georgia Bureau of Investigation regarding the possible commission of a crime, the Investigations Section consults with the Division Director prior to contacting the GBI.

4. The state hospital/community provider/support coordinator/support broker immediately reports all Category I critical incidents to the Regional Hospital Administrator/community provider administrator or support coordination/support broker administrator. The support coordinator/support broker immediately reports all Category I critical incidents to the support coordination agency chief executive officer.

5. When a consumer has an assigned support coordinator, the state hospital or community provider notifies the support coordinator of the critical incident within 24 hours.

6. For critical incidents that must be reported to other agencies or offices as required by law or regulation, the state hospital/community provider

or support coordinator/support broker is responsible at all times for notifying such agencies and offices in a timely manner (See Attachment C)

7. High Visibility Incidents

   - The state hospital/community provider or support coordinator/support broker immediately reports all high visibility Category I and II critical incidents to the Investigations Section by telephone. This call must be made as soon as possible, but at least within two (2) hours of the high visibility incident.
   - A *Critical Incident Report* form (Attachment B) must be submitted electronically on the same day as the high visibility incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.
   - The Investigations Section notifies the Director of MHDDAD, the Regional Coordinator, and the Department of Human Resources (DHR) Office of Communications of high visibility incidents.

8. For all other Category I critical incidents, the state hospital/community provider submits the *Critical Incident Report* form (Attachment B) electronically to the Investigations Section on the same day as the Category I incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.

9. For all other Category II critical incidents, The *Critical Incident Report* (Attachment B) is electronically sent to the Investigations Section within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.

C. Reports of Incidents by persons other than staff of state hospitals or community providers

1. Consumers, family members of consumers, support coordinators, support coordinator/support brokers, or any other persons may initiate reports of critical incidents as needed. In consumer-directed services, the consumer's support coordinator/support broker has responsibility for receiving information from the consumer's support system about critical incidents as they occur. The support coordinator/support broker then reports critical incidents in accordance with procedures outlined in section III, A. and B.

2. Support coordinators/support brokers report critical incidents in accordance with procedures outlined in section III, A and B upon discovery of incidents not already reported by state hospitals of community providers.

3. When information about a critical incident is received by a state hospital/community provider or support coordinator/support broker from any person other than support coordinators, the staff receiving the information completes the *Critical Incident Report* form and follows procedures outlined in section III, A and B.

4. When information about a critical incident is received by the Investigations Section, the staff receiving the information completes the *Critical Incident Report* form.

D. Agency managerial review of *Critical Incident Report* form

1. Administrators of state hospitals, community providers or support coordination agencies perform a managerial review of all *Critical Incident Reports*. The reviewer at a minimum:

   - Reads the *Critical Incident Report*;
   - Reads all statements and reports associated with the incident;
   - Requires and ensures the completion of any incomplete or missing documentation; and
   - Signs by attestation as the managerial reviewer on the *Critical Incident Report* form (Attachment B).

2. The Regional Hospital Administrator, community provider administrator or support coordination administrator designates an executive staff to conduct the managerial review of all *Critical Incident Report* forms (Attachment B).

3. The Investigations Section reviews all *Critical Incident Reports* for completeness and contacts the state hospital/community provider or support coordination/support broker agency for changes and additional information, as appropriate.

E. Computer data entry

1. DMHDDAD maintains a critical incident database to identify patterns and to perform trend analyses.

2. Access to the critical incident database must be granted by the Investigations Section, and is limited to staff of providers of agencies operated by, or under contract or Letter of Agreement (LOA) with, the Division.

3. Each state hospital, community provider and support coordination agency designates one or more persons to be responsible for entering critical incident and death information into the database. Entries must be made within one business day of the incident or knowledge of the incident.

4. Access to the critical incident database must be requested from the Investigations Section.

F. Investigation of Critical Incidents

1. The Investigations Section conducts investigations of Category I critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents policy, 2.201. If the Investigations Section determines that the state hospital/community provider or support coordination agency should conduct the investigation, the provider is notified within three (3) hours of receipt of the initial report.

2. State hospitals and community providers conduct investigations of Category II critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents policy, 2.201. Support coordination agencies conduct investigations of Category II critical incidents for consumer directed services.

G. Procedures for Data Analysis

1. The critical incidents reporting processes are monitored by the Investigations Section to include:

   - Timeliness of Critical Incident Reports entered into the database; and
   - Accuracy of Critical Incident Reports entered into the database.

2. State hospitals/community providers and support coordination agencies have procedures for analyzing incident patterns. Incidents include the following:

- Incidents not required to be reported by this policy utilized for internal quality improvement programs; and
- Incidents reported through this policy.

3. Information about incidents is utilized by the Division's Quality Improvement program to evaluate the quality of services.

Critical Incident Definitions & Reporting Requirements

Category	Incident Type	Definition	Reporting Requirements
I	**Unexplained Death**	An **unexplained** death is the death of a state hospital or community residential consumer that is not related to a previously diagnosed medical condition, or that could be attributed to abuse or neglect. Additionally, the suicide of a consumer receiving any type of services is an unexplained death. Includes the unexplained death of any consumer: • Of a community residential program (staffed home or 24/7 personal support) • On the census of a state hospital or state operated community program • Enrolled in consumer-directed services • Occurring on site of a community provider or state hospital • In the company of staff of a community provider or state hospital • Absent without leave from inpatient or residential services • Occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider • Transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider custody, regardless of the time that has elapsed since the transfer or discharge	**State Hospitals** *Regional Hospital Administrators immediately report unexplained deaths to the MHDDAD Division Director by telephone. *Report to the investigations Section by telephone as soon as possible (but at least within two hours). *Submit a typed Critical Incident Report electronically on the same day as the consumer death or on the next business day if death occurred after hours or on a weekend/holiday. **Community Providers and Support Coordinators/Support Brokers** *Report unexplained death by telephone to the Investigations Section as soon as possible, but at least within two hours. *Submit a typed Critical Incident Report electronically on the same day as the consumer death or on the next business day if the death occurred after hours or on a weekend/holiday.
I or II	**High Visibility**	Critical Incidents listed as Category I or II, which have system wide impact, have relevance to ongoing litigation of DHR and or are likely to be reported in the media are considered to be high visibility incidents.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Report immediately by telephone to the Investigations section. This call must be made as soon as possible, but at least within two hours of the high visibility incident. *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after hours or on a weekend or holiday.

Critical Incident Definitions & Reporting Requirements

I	**(Allegation of) Physical abuse**	The willful infliction of physical pain, physical injury, or unreasonable confinement. For purposes of this policy, "willful" means other than accidental. Does not include sexual assault or exploitation. Does not include approved physical interventions when appropriately utilized.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.
I	**(Allegation of) Neglect**	The failure of an employee or an organization to provide goods, services and supervision necessary to avoid physical harm, mental anguish or mental illness or creates a significant risk of injury or death to a consumer.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.
I	**(Allegation of) Staff to consumer sexual assault or sexual exploitation**	Any sexual contact between an employee and a consumer. Includes the solicitation of a consumer by an employee for sexual purposes.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.
I	**(Allegation of) Consumer to consumer sexual assault or sexual exploitation**	Forced sexual activity between consumers.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.
I	**Medication errors with adverse consequences**	Medication error includes omission and wrong dose, time, person, medication, route, position, technique/method and form. Adverse consequences are those that cause the consumer discomfort or jeopardizes his/her health and safety. Does not include refusal of medication by consumer.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.
I	**Seclusion or restraint resulting in injury requiring treatment beyond first aid**	Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures. Injury includes any physical harm or damage that requires	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.

Critical Incident Definitions & Reporting Requirements

		treatment beyond first aid or more serious treatment. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital.	
I	**Suicide attempt that results in medical hospitalization**	The consumer receiving any type of services (including outpatient services) is hospitalized for medical reasons related to injuries from a suicide attempt.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the incident or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Death**	The expected or explained death is the death of a state hospital or community residential consumer usually related to a known medical condition. This does not include Unexplained Deaths in Category I Includes the expected or explained death of any consumer: • In a community residential program (staffed home or 24/7 personal support) • On the census of a state hospital or state operated community program • Enrolled in consumer-directed services • On site with a community provider or hospital • In the company of staff of a community provider or hospital • Absent without leave from inpatient or residential services • Occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider • Transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider custody, regardless of the time that has elapsed since the transfer or discharge	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically on the same day as the death or on the next business day if the consumer's death occurred after business hours or on a weekend/holiday.

Critical Incident Definitions & Reporting Requirements

II	**(Allegation of) Verbal Abuse**	The use of words or gestures by an employee to threaten, coerce, intimidate, harass or humiliate a consumer.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**(Allegation of) Financial Exploitation**	The illegal or improper use of an individual's labor, property or resources for another's profit or advantage. The failure to account for the consumer's funds by a payee.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Consumer who leaves grounds or state hospital without permission**	Reportable events include: • Consumer is absent from a designated location and cannot be found w/in the hospital campus • Consumer who is off campus but under direct observation of hospital staff (e.g., appointment, recreational activity, being transported) is absent from the designated location Not included are events where consumer is not under supervision of hospital staff and fails to return to designated location at designated time (i.e., failure to return from authorized leave).	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Consumer who is unexpectedly absent from community residential program**	Consumer has left the residence without knowledge of staff and whose location is not known. Would include all absences where law enforcement is notified.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Seclusion or restraint resulting in injury requiring minor first aid**	Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures. Injury includes any physical harm or damage that requires minor first aid. Minor first aid is meant to include treatments such as the application of band-aids, steri-strips,	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.

Critical Incident Definitions & Reporting Requirements

		dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.	
II	**Vehicular accidents with injury while consumer is in a state vehicle or is being transported by community or hospital staff**	The injury required treatment beyond minor first aid. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Incident occurring at a provider's site which required the intervention of law enforcement services**	Includes 911 calls from staff for assistance, as well as reports to law enforcement of theft of consumer property by employees or non-employees while at the provider site or accompanied by staff.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Criminal conduct by consumer**	Conduct while on the site of the provider or when accompanied by staff. Would also include criminal conduct of a consumer who leaves the grounds of a state hospital without permission and/or a consumer who is unexpectedly absent from a community residential program. At a state hospital, criminal conduct is reported only if the administrator has determined that a criminal report will be filed with local law enforcement.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Consumer to consumer assault resulting in injury requiring treatment beyond first aid**	Assaults or incidents occurring at the provider site or while in the company of provider staff. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.

Critical Incident Definitions & Reporting Requirements

II	**Consumer to consumer assault with injury requiring minor first aid**	Assaults or incidents occurring at the provider site or while in the company of provider staff. Minor first aid is meant to include treatments such as the application of band-aids, steri-strips, dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Medical hospitalization of a consumer of a state hospital or community residential program**	Any emergency admission to a medical facility, either directly or through the facility's emergency room. Would not include planned admissions, such as for elective surgery.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.
II	**Consumer injury requiring treatment beyond first aid**	Includes accidents; does not include illness. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital.	**State Hospitals, Community Providers and Support Coordinators/Support Brokers** *Submit a typed Critical Incident Report electronically within twenty four hours or on the next business day if the incident occurred after business hours or on a weekend/holiday.

CRITICAL INCIDENT REPORT FORM

Incident #

Date of Report _____ Date of Incident/Death: _____

Date of Discovery of Incident/Death: _____ Time of Incident/Death: _____

State Hospital reporting:

Community Provider reporting: _____

If reporting provider is a subcontractor, who is primary contractor? _____

Contact Person: _____ Contact Person phone #: _____

MHDDAD Region #: _____ Person Completing Report: _____

Name of site and/or specific location where incident/death occurred (i.e.: Unit name/number, name of PCH, etc):

Check appropriate box State Hospital ☐ Crisis Stabilization ☐ Day Program ☐ In Community ☐

Community Residential Program ☐ Respite ☐ Personal Residence ☐ Local Hospital ☐

Other *(please specify)*: _____

Consumer(s) Information*

Name _____ DOB _____ Age at Time of Incident _____ Sex _____

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes ☐ No ☐ CID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH ☐ DD ☐ AD ☐ Check box if consumer directed services ☐

List agency services in which consumer is enrolled:

Extent of Injury:

None ☐ No visible injury ☐ Minor first aid on site ☐ Outpatient treatment ☐ Inpatient treatment ☐

Brief description of injury

Name _____ DOB _____ Age at Time of Incident _____ Sex _____

Address _____ City _____ State GA Zip _____ County _____

Medicaid Waiver? Yes ☐ No ☐ CID # _____ SS# _____ Race _____

Admission Date _____ Disability: MH ☐ DD ☐ AD ☐ Check box if consumer directed services ☐

List agency services in which consumer is enrolled:

Extent of Injury:

None ☐ No visible injury ☐ Minor first aid on site ☐ Outpatient treatment ☐ Inpatient treatment ☐

Brief description of injury

*Add additional consumers on a separate sheet with all required information.

CRITICAL INCIDENT REPORT FORM

Type of Incident

Category I *(check all that apply)* **Check here if incident is high visibility** ☐

☐	Unexplained death *(please complete death section)*
☐	(Allegation of) Physical abuse
☐	(Allegation of) Neglect
☐	(Allegation of) Staff to consumer sexual assault or sexual exploitation
☐	(Allegation of) Consumer to consumer sexual assault or sexual exploitation
☐	Medication errors with adverse consequences
☐	Seclusion/restraint resulting in injury requiring treatment beyond first aid
☐	Suicide attempt that results in medical hospitalization

Category II *(check all that apply)* **Check here if incident is high visibility** ☐

☐	Death (other than unexplained) *(please complete death section)*
☐	(Allegation of) Verbal abuse
☐	(Allegation of) Financial exploitation
☐	Consumer who leaves the grounds of a state hospital without permission
☐	Consumer who is unexpectedly absent from a community residential program
☐	Seclusion/restraint resulting in injury requiring minor first aid
☐	Vehicular accident with injury while consumer is in a state vehicle or is being transported by community or hospital staff
☐	Incident occurring at provider's site which required intervention of law enforcement services
☐	Criminal conduct by consumer
☐	Consumer to consumer assault resulting in injury requiring treatment beyond first aid
☐	Consumer to consumer assault with injury requiring minor first aid
☐	Medical hospitalization of a consumer of a state hospital or community residential program
☐	Consumer injury requiring treatment beyond first aid
☐	Incident that does not meet Category I or II criteria

Brief description of incident (add additional information on separate page if needed):

CRITICAL INCIDENT REPORT FORM

Witnesses to Incident

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Name _____ **Contact #** _____ Staff ☐ Consumer ☐ Other ☐

Notifications

Agency	Name	Date/time	Method of Notification
Adult Protective Services			
CPS/DFCS			
Office of Regulatory Services			
Support Coordinator/Broker			

Deaths (if applicable)

How was death discovered?

Date of last contact with consumer: _____ **Reason for contact:** _____

Was death expected? Yes ☐ No ☐ **Was death an accident?** Yes ☐ No ☐

Possible suicide? Yes ☐ No ☐ **Possible Homicide?** Yes ☐ No ☐

Presence of Significant disease processes/factors in death ***(check all that apply)***

Aspiration Pneumonia/Pneumonia ☐ Bowel Obstruction ☐ Cancer ☐ Choking ☐ Diabetes ☐

Heart Disease ☐ History of Strokes ☐ Infections ☐ Influenza ☐ Liver Disease ☐

Lung Disease ☐ Medication Related ☐

Has autopsy been ordered? Yes ☐ No ☐	**If not state reason:**

Cause of death, when known:

Were there unusual circumstances surrounding death? Yes ☐ No ☐ **If yes, please describe below**

Administrator's Review for all critical incidents

State Hospital/Community provider staff/title: _____

Date: _____

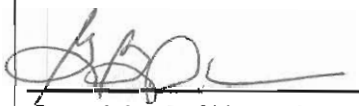
☐ **By checking this box, I attest that the above entry for State hospital/community provider staff/title verifies my review of the incident.**

Incidents to report to other agencies, in addition to MHDDAD[1]

Consumer Group	Incidents(s) to Report	Report to whom?	Timeframe
Disabled adults in personal care homes or CLAs	Death of a resident; rape of resident; allegation of abuse, neglect or exploitation	ORS-Long Term Care Section	24 hours, or the next business day
Children in outdoor therapeutic programs	Death or serious injury (requiring extensive medical care and/or hospitalization of any camper in care); suicide attempts; abuse	ORS-Childcare Licensing Section Fax form to ORS	48 hours, or the next working day
Persons residing in skilled nursing facilities	Allegations of abuse, neglect or exploitation; injuries of unknown origin; misappropriation of resident property	ORS-Long Term Care Fax form to ORS	Report within 24 hours For Medicaid-participating nursing homes, results of investigations must be reported within 5 working days
Persons in hospital	Unanticipated death not related to natural course or underlying disease; allegation of rape or sexual assault	ORS-Health Care Section Fax form to ORS	Within 24 hours of next business day
Persons in ICF/MR	Allegation of abuse or neglect with injury requiring treatment beyond first aid; time-out or restraint resulting in injury requiring treatment beyond first aid; death not related to course of illness or underlying condition; allegation of rape or sexual assault	ORS-Health Care Section Fax form to ORS	Within 24 hours or next business day

Disabled adult or elder person in the community or outside of a nursing home, personal care home or community living/group home	Abuse or neglect and danger is not immediate	Call Adult Protective Services 1-888-774-0152	Immediately or next business day
Child under the age of 18	Abuse or neglect	Local law enforcement and/or/ local DFCS office	Immediately notify law enforcement if there is immediate danger
Persons in narcotic treatment program	Death; serious injury at program requiring medical care; rape occurring at program; abuse, neglect or exploitation of patient by staff; emergency situation that affects safe operation of program	ORS	Within 24 hours or next business day

[1]This is only a summary. The reader must obtain detailed instructions and definitions directly from the responsible agency.

Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases	POLICY NO: 2.201
Applicability: • State Hospitals • Public and Private community providers • OTP & State-operated community programs • State MHDDAD office • Regional MHDDAD offices	REFERENCE: Official Code of Georgia 37-1-2; 37-1-20; 37-2-1 et seq.; 37-3-166; 37-3-2; 37-4-125; 37-4-3; 37-7-166; 37-7-2; 30-5-1 et seq.; 19-7-5; 16-6-5.1; DHR Rules and Regulations for Patients' Rights, Chapters 290-4-6; DHR Rules and Regulations for Clients' Rights 290-4-9.
SUBJECT: **Investigating Consumer Deaths and Critical Incidents**	**Effective date: October 1, 2006** **Scheduled Review Date:**
Attachments: A-Critical Incident Definitions & Investigative Requirements B-Final Investigative Report Format C-Medical Hospitalization Follow-up Report D-Consumer Injury requiring treatment beyond first aid Follow-up Report E- Administrative Review form F-Request for Extension G-Corrective Action Plan Format	**APPROVED:**  **Gwendolyn B. Skinner, Director MHDDAD**

I. POLICY

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) to maintain a safe and humane environment for consumers, and to prevent abuse, neglect and exploitation of consumers. The DMHDDAD uses a standardized process for reporting and investigating deaths and critical incidents that involve consumers being served by the DMHDDAD in state hospitals and community providers. The process also includes procedures for consumers who are participating in waiver program consumer directed services.

II. DEFINITIONS

Category I Incidents

- Unexplained Death (including suicides)
- (Allegation of) Physical abuse
- (Allegation of) Neglect
- (Allegation of) Staff to consumer sexual assault or sexual exploitation
- (Allegation of) Consumer to consumer sexual assault or sexual exploitation
- Medication errors with adverse consequences
- Seclusion or restraint resulting in injury requiring treatment beyond first aid
- Suicide attempt that results in medical hospitalization

Category II Incidents

- Death (other than unexplained)
- (Allegation of) Verbal abuse
- (Allegation of) Financial exploitation
- Consumer who leaves the grounds of a state hospital without permission
- Consumer who is unexpectedly absent from a community residential program
- Seclusion or restraint resulting in injury requiring minor first aid
- Vehicular accident with injury while consumer is in a state vehicle or is being transported by community or hospital staff
- Incident occurring at a provider's site which required intervention of law enforcement services
- Criminal conduct by consumer
- Consumer to consumer assault resulting in injury requiring treatment beyond first aid
- Consumer to consumer assault with injury requiring minor first aid
- Medical hospitalization of a consumer of a state hospital (including state operated community programs) or community residential program
- Consumer injury requiring treatment beyond first aid

See Attachment A for definitions of incidents.

Community Provider: Any person or entity providing community-based disability services through a contract with or authorized by the DMHDDAD and/or providing Medicaid services authorized by DMHDDAD. "Community Provider" includes any state owned or operated community program. For purposes of this policy, community provider includes services provided through a subcontractor.

Community Residential Consumer: A consumer receiving MHDDAD services in a home that is staffed by a provider organization and/or a consumer receiving personal support 24 hours/7 days a week.

Consumer: An individual enrolled with a community provider for disability services, seeking services or admission at a state hospital, or on the census of a state hospital or state operated community program.

Consumer-Directed Services: A model for service delivery in which consumers have the option to control and direct Medicaid funds identified in an individual budget, and in which the consumers live in their own homes. The consumer hires and fires direct support staff, and works with a support coordinator/support broker to receive assistance needed with self-directing services.

Corrective Action Plan: A document which identifies and analyzes problems within the provider organization and prescribes corrective action steps which, when implemented, are likely to prevent the recurrence of similar problems and improve the quality of consumer care. A corrective action plan must identify the person(s) responsible for ensuring that action steps are completed and reviewed for efficacy and establishes a schedule for completion and follow-up of all action steps.

Critical Incident: Any event that involves an immediate threat to the care, health or safety of any consumer in community residential services, on site with a community provider or hospital, in the company of a staff member of a community provider or hospital, absent without leave from inpatient or residential services, or enrolled in consumer-directed services. Critical incidents include, but are not limited to, all incidents as listed in categories I and II.

Critical Incident Database: DMHDDAD web-based system for entering data about critical incidents.

Disability Services: Direct services to an individual, or services, which are designed to prevent or ameliorate the effect of a disability.

Final Investigative Report: A written summary of an investigation conducted by the Investigation Section, state hospitals or community providers of an alleged critical incident or death and approved by the Director of the Investigations Section or designee.

High-Visibility Incident: Critical incidents as defined in this policy, which have system-wide impact, have impact upon, or relevance to, any ongoing litigation of DHR or DMHDDAD, or may have significant impact upon, or significant relevance to, issues of DHR or DMHDDAD public concern and/or are likely to be reported in the media.

Investigator: A trained staff person who is designated to perform investigations into critical incidents.

Senior Executive Manager: The supervisor administratively in charge at the time of the incident.

State Hospital: A state Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) hospital facility.

Support Coordinator: In DMHDDAD developmental disability services, the independent case manager for each consumer.

Support Coordinator/Support Broker: In consumer-directed services, the specific support coordinator who has responsibility for working with the consumer and the consumer's support system as a team to assist the consumer to manage his or her direct support needs and budgeting. The support coordinator/support broker has responsibility for ensuring reporting of critical incidents.

Support System: In consumer-directed services, the consumer's support system includes direct support workers, family, friends and neighbors. The support coordinator/support broker has responsibility for receiving information from the support system about critical incidents as they occur.

III. PROCEDURES

A. Investigation of Critical Incidents, other than medical hospitalization, consumer injury requiring treatment beyond first aid and consumer to consumer assault with injury requiring minor first aid:

1. Designated staff who are trained and qualified can conduct investigations of critical incidents.

2. The investigator, at a minimum:

   - Interviews consumers, staff and other involved parties;
   - Reviews all related documentation; and
   - Collaborates with outside agencies, as applicable.

3. All investigations must be thorough and must address, at a minimum, those items identified in the Final Investigative Report Format (Attachment B).

4. If, at any time during the investigation, evidence of criminal conduct is discovered the investigator immediately notifies the senior executive manager who notifies law enforcement authorities.

5. If law enforcement authorities initiate an investigation regarding the incident, the state hospital/community provider staff cooperate with law enforcement authorities.

6. If, at any time during an investigation, it appears that a community provider or its staff has failed to protect the health, safety and/or welfare of the consumers in its care, the Investigations Section

requests that the Regional Coordinator take immediate steps to protect such consumers, including the removal of the consumer(s) to another community provider, if needed. The Regional Coordinator, or his/her designee, notifies the Investigations Section of actions taken.

7. The investigator completes the investigation and submits the typed *Final Investigative Report* (Attachment B) within thirty (30) calendar days following the date of the incident or discovery of the incident.

8. If there is a compelling reason why the investigation cannot be completed within thirty (30) days, a *Request for Extension* form (Attachment F) is filled out and submitted to the Investigations Section outlining the reasons and giving an expected completion date. Such requests are received by the Investigations Section at least five (5) calendar days prior to report due date. The Investigations Section will establish a new deadline, not to exceed thirty (30) calendar days.

9. The results of investigations of the following incidents involving the following consumers are reported to the Regional Hospital Administrator within five (5) working days of the incident:

   - Skilled nursing facilities- Allegations of abuse, neglect or exploitation; injuries of unknown origin; misappropriation of consumer property; or
   - ICF/MR-Allegation of abuse or neglect with injury requiring treatment beyond first aid; time-out or restraint resulting in injury requiring treatment beyond first aid; death not related to course of illness or underlying condition; allegation of rape or sexual assault.

B. Incident types not requiring investigative reports:

1. The following Category II incidents require the hospital/community program to submit the *Critical Incident Follow-up Report* specific to that type of incident rather than conducting a formal investigation.

   - Medical hospitalization of a consumer of a state hospital or community residential program (see attachment C).
   - Consumer injury requiring treatment beyond first aid (see attachment D).

a. The state hospital/community provider designates qualified staff trained to do investigations and to complete *Critical Incident Follow-up Reports.* (Attachments C and D)

b. The investigator completes and submits the *Critical Incident Follow-up Report* to the Investigations Section within thirty (30) calendar days following the date of the incident or discovery of the incident.

c. If there is a compelling reason why the follow-up report cannot be completed within thirty (30) days, a *Request for Extension* form (Attachment F) is filled out and submitted to the Investigations Section outlining the reasons and giving an expected completion date. Such requests are received by the Investigations Section at least five (5) calendar days prior to report due date. The Investigations Section will establish a new deadline, not to exceed thirty (30) calendar days.

2. The Category II incident of consumer to consumer assault resulting in injury requiring minor first aid will be tracked by the provider through a statistical summary submitted twice yearly to the Investigations Section to include an analysis of trends, identification of opportunities for improvement and a description of changes in agency practice that are designed to reduce the numbers of consumer injuries.

3. The Investigations Section may request a Final Investigative Report instead of or in addition to the above alternative report formats, such as, in cases of repeated incidents for individual consumers.

C. Agency Managerial Review

1. The administrators of state hospitals, community providers and support coordination agencies perform a managerial review of all the *Final Investigative Reports* and *Critical Incident Follow-up Reports* completed within that agency. The reviewer at minimum:

   - Reads the *Final Investigative Report* or *Follow-up Report*;
   - Reads all accompanying documentation;
   - Requires and ensures the completion of any incomplete or missing documentation; and
   - Signs off as the managerial reviewer on the *Final Investigative Report* or *Follow-up Report*.

2. The state hospital, community provider, or support coordination agency designates trained staff who are qualified to perform the review and sign off as the agency representative.

D. MHDDAD Investigations Section Administrative Review

1. The Investigations Section reviews all *Final Investigative Reports* and *Critical Incident Follow-up reports* completed by state hospitals, community providers and support coordination agencies for content, thoroughness of the investigation, and demonstration that conclusions are supported by evidence available. The reviewer, at a minimum:

   - Reads the *Final Investigative Report* or *Follow-up Report*;
   - Reads all accompanying documentation;
   - Requires and ensures the completion of any incomplete or missing documentation;
   - Evaluates whether the conclusions of the investigation or follow-up report is supported by the evidence documented;
   - Completes the *Review of Final Investigative* Report form (Attachment E); and
   - Makes recommendations regarding the need for corrective action by the hospital/community program:

2. The Director of the Investigations Section or designee may overturn findings of investigations conducted by hospital or community providers.

3. Hospital administrators or community provider executive managers are contacted by telephone when findings are overturned.

4. For Final Investigative Reports or follow up reports completed by the state hospital/community provider or support coordination agency that are deemed inadequate, the Investigations Section returns the report to the state hospital/community provider or support coordination agency for corrections or additional information.

5. The Director of Investigations or his/her designee reviews all *Final Investigative Reports* completed by the Investigations Section. The reviewer at a minimum:

   - Reads the *Final Investigative Report*;
   - Reads all accompanying documentation;
   - Requires and ensures the completion of any incomplete or missing documentation;
   - Signs off as the administrative reviewer on the *Final Investigative Report*; and

- Makes recommendations regarding the need for corrective action by the hospital/community program as needed.

6. The Division Medical Director conducts and documents a review of all consumer death files.

E. Corrective Action Plans and follow-up

1. Upon completion and review of the *Final Investigative Report* the Investigations Section notifies the state hospital/community provider/support coordination/support broker agency if there is need for a Corrective Action Plan (CAP).

2. A CAP (Attachment G) must be submitted to the Investigations Section within the timeframe established by the request.

3. The Investigations Section accepts or makes recommendations for changes to the CAP and involves the Regional Coordinator as necessary.

4. For CAPs that are not completed successfully by contracted providers, the Regional Coordinator coordinates appropriate contract actions with DMHDDAD Legal Services.

F. Review of Final Investigative Report by Regional Coordinator

1. Investigations Section sends all Final Investigative Reports, Administrative Reviews and Corrective Action Plans to the Regional Coordinator.

2. It is the responsibility of the Regional Coordinator to follow-up with the provider when necessary, and to ensure that the provider has taken the appropriate corrective steps to correct unsafe conditions.

G. Distribution of *Final Investigative Reports, Follow-up Reports and* Corrective Action Plans

1. After approval of Final Investigative Reports, Follow up Reports and/or Corrective Action Plans, the Investigations Section will distribute reports/plans to the Regional Coordinator, and the Regional Hospital Administrator or Community Program Executive Director.

**Critical Incident Definitions &
Investigative Requirements**

Category	Incident Type	Definition	Investigative Requirements
I	**Unexplained Death**	An **unexplained** death is the death of a state hospital or community residential consumer that is not related to a previously diagnosed medical condition, or that could be attributed to abuse or neglect. Additionally, the suicide of a consumer receiving any type of services is an unexplained death. Includes the unexplained death of any consumer: • Of a community residential program (staffed home or 24/7 personal support) • On the census of a state hospital or state operated community program • Enrolled in consumer-directed services • Occurring on site of a community provider or state hospital • In the company of staff of a community provider or state hospital • Absent without leave from inpatient or residential services • Occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider • Transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider custody, regardless of the time that has elapsed since the transfer or discharge	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
I or II	**High Visibility**	Critical Incidents listed as Category I or II, which have system wide impact, have relevance to ongoing litigation of DHR and or are likely to be reported in the media are considered to be high visibility incidents.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
I	**(Allegation of) Physical abuse**	The willful infliction of physical pain, physical injury, or unreasonable confinement. For purposes of this policy, "willful" means other than accidental. Does not include sexual assault or exploitation. Does not include approved physical interventions when appropriately utilized.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the

**Critical Incident Definitions &
Investigative Requirements**

			incident or discovery of the incident.
I	**(Allegation of) Neglect**	The failure of an employee or an organization to provide goods, services and supervision necessary to avoid physical harm, mental anguish or mental illness or creates a significant risk of injury or death to a consumer.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
I	**(Allegation of) Staff to consumer sexual assault or sexual exploitation**	Any sexual contact between an employee and a consumer. Includes the solicitation of a consumer by an employee for sexual purposes.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
I	**(Allegation of) Consumer to consumer sexual assault or sexual exploitation**	Forced sexual activity between consumers.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
I	**Medication errors with adverse consequences**	Medication error includes omission and wrong dose, time, person, medication, route, position, technique/method and form. Adverse consequences are those that cause the consumer discomfort or jeopardizes his/her health and safety. Does not include refusal of medication by consumer.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
I	**Seclusion or restraint resulting in injury requiring treatment beyond first aid**	Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures. Injury includes any physical harm or damage that requires treatment beyond first aid or more serious treatment. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.

**Critical Incident Definitions &
Investigative Requirements**

		hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital.	
I	**Suicide attempt that results in medical hospitalization**	The consumer receiving any type of services (including outpatient services) is hospitalized for medical reasons related to injuries from a suicide attempt.	If the Investigations Section directs the state hospital or community program or support coordinator/support broker to conduct the investigation, the Final Investigative Report will be submitted by mail within thirty days of the incident or discovery of the incident.
II	**Death**	The expected or explained death is the death of a state hospital or community residential consumer usually related to a known medical condition. This does not include Unexplained Deaths in Category I Includes the expected or explained death of any consumer: • In a community residential program (staffed home or 24/7 personal support) • On the census of a state hospital or state operated community program • Enrolled in consumer-directed services • On site with a community provider or hospital • In the company of staff of a community provider or hospital • Absent without leave from inpatient or residential services • Occurring within two (2) weeks following the consumer's discharge from a state hospital or community residential provider • Transferred or discharged to a medical facility for treatment of any illness or injury that occurred during hospital or community provider custody, regardless of the time that has elapsed since the transfer or discharge	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**(Allegation of) Verbal Abuse**	The use of words or gestures by an employee to threaten, coerce, intimidate, harass or humiliate a consumer.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.

**Critical Incident Definitions &
Investigative Requirements**

II	**(Allegation of) Financial Exploitation**	The illegal or improper use of an individual's labor, property or resources for another's profit or advantage. The failure to account for the consumer's funds by a payee.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Consumer who leaves the grounds of a state hospital without permission**	Reportable events include: • Consumer is absent from a designated location and cannot be found w/in the hospital campus • Consumer who is off campus but under direct observation of hospital staff (e.g., appointment, recreational activity, being transported) is absent from the designated location. Not included are events where consumer is not under supervision of hospital staff and fails to return to designated location at designated time (i.e., failure to return from authorized leave).	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Consumer who is unexpectedly absent from a community residential program**	Consumer has left the residence without knowledge of staff and whose location is not known. Would include all absences where law enforcement is notified.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Seclusion or restraint resulting in injury requiring minor first aid**	Seclusion or restraint includes physical holding, as well as mechanical restraints, and time-out. This would not include postural supports or restraints for medical or surgical procedures. Injury includes any physical harm or damage that requires minor first aid. Minor first aid is meant to include treatments such as the application of band-aids, steri-strips, dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Vehicular accident with injury while consumer is in a state vehicle or**	The injury required treatment beyond minor first aid. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.

**Critical Incident Definitions &
Investigative Requirements**

	is being transported by community or hospital staff	hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital.	
II	**Incident occurring at a provider's site which required intervention of law enforcement services**	Includes 911 calls from staff for assistance, as well as reports to law enforcement of theft of consumer property by employees or non-employees while at the provider site or accompanied by staff.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Criminal conduct by consumer**	Conduct while on the site of the provider or when accompanied by staff. Would also include criminal conduct of a consumer who leaves the grounds of a state hospital without permission and/or a consumer who is unexpectedly absent from a community residential program. At a state hospital, criminal conduct is reported only if the administrator has determined that a criminal report will be filed with local law enforcement.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Consumer to consumer assault resulting in injury requiring treatment beyond first aid**	Assaults or incidents occurring at the provider site or while in the company of provider staff. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital.	The state hospital or community provider or support coordinator/support broker will submit a Final Investigative Report by mail to the Investigations Section within thirty days of discovery of the incident.
II	**Consumer to consumer assault with injury requiring minor first aid**	Assaults or incidents occurring at the provider site or while in the company of provider staff. Minor first aid is meant to include treatments such as the application of band-aids, steri-strips, dermabond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen.	Consumer to consumer assaults requiring minor first aid will be tracked through a statistical summary, submitted twice yearly to include an analysis of trends, identification of opportunities for improvement and description of changes in agency practice that are designed to reduce the numbers of consumer injuries.

**Critical Incident Definitions &
Investigative Requirements**

II	**Medical hospitalization of a consumer of a state hospital or community residential program**	Any emergency admission to a medical facility, either directly or through the facility's emergency room. Would not include planned admissions, such as for elective surgery.	Medical Hospitalization Follow Up Report (Attachment C) will be submitted to the investigations Section by mail within thirty days of discovery of the incident.
II	**Consumer injury requiring treatment beyond first aid**	Includes accidents; does not include illness. The injury received is severe enough to require the treatment of a consumer by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may be provided within the facility or outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a hospital.	Consumer Injury Requiring Treatment Beyond First Aid Follow Up Report (Attachment D) will be submitted to the Investigations Section by mail within thirty days of discovery of the incident.

FINAL INVESTIGATIVE REPORT FORMAT

To the User: *This format is used for the summary of an investigation. However, not all of the items listed below will be necessary for all incidents. It is the responsibility of the agency to comply with the requirements of Policy 2.201 with regard to content. The "Guidelines" are to help the writer answer questions that may be applicable to the incident. Please do NOT include the questions in the submitted Final Investigative Report.*

Date of Report:

Provider Agency:
Contact Person:
Sub-Contractor:
Investigator:
Date of Incident:
Date of Investigation:
Type of Incident:
MHDDAD Region:

Consumer Name:
Address:

Date of Birth:
Age at time of incident:
MHID/CID #:

SUMMARY OF ALLEGATION(S)/INCIDENT:

Guidelines

What happened? Who reported it and to who was the incident or allegation reported to? Where, When and How was it reported?
(List each allegation or problem area separately.)

CHRONOLOGY OF INCIDENT:

Guidelines
What happened from the time of the immediate precipitating or causal events of the incident or allegation until the time of the investigation? (Date and time each significant event.)
What or who is the source of information?
If occurring at a residential site/group home/program site, when was assistance (such as emergency or administrative) requested?
If the staff was directed to or decided to obtain medical treatment, when was it obtained and, if not obtained immediately, what was the reason for waiting?

If this is a death, include any information available from the coroner or others about the possible cause of death. Also include any information about the consumer's condition prior to death.

INVESTIGATIVE METHODS:

Guidelines
Date and time investigation initiated
What physical, written documents, interviews, witness statements, and evidence was collected and considered?
What agencies were involved with incident?
What agencies were notified of the incident?

People Interviewed:

DOCUMENTS REVIEWED:

SUMMARY OF FINDINGS:

Consumer Profile:

Provider Profile:

Summary of Interviews:

(1) List relevant information obtained in each interview.
(2) Be sure to give information regarding person interviewed, such as job title, training, relationship to consumer etc, bias or credibility issues etc.

The following people were interviewed but did not provide new information concerning the current investigation:

CONCLUSIONS:

Guidelines
Do the findings substantiate or not substantiate the reported allegation/incident?
(List each allegation or problem area, and then respond to each separately.)
Could the allegation/incident be substantiated but the cause remains undetermined?
Did staff respond to the incident in a timely and appropriate manner?
Did staff follow established procedures when responding to the incident?

FOR DEATHS (if applicable):

Please list any of the following procedures that were utilized in the review of this death: review by medical director or other physician, medical peer review, sentinel event protocol (Joint Commission accredited facilities, only.) Do not attach copies of any peer review documents. Simply state what was done, by whom, and the date.

Review by DMHDDAD Medical Director

The Medical Director reviews all deaths in accord with Division policy.

RECOMMENDATIONS:

Guidelines
What actions can be taken by the provider to make corrections and prevent recurrence?

ATTACHMENTS:

Guidelines
List of documents reviewed
List of witnesses (identifying who was interviewed and, if not, the reason for no interview) and status (consumer, staff, family, etc.)
Witness statements
Interview statements
Agency policies & procedures (specifically related to investigation and needed for explanation of the investigative findings)
Photographs
Graphs, charts, maps

Investigated By:

_____ _____
Name/Title **Date**

Reviewed and Approved By:

_____ _____
Agency Director/Regional Hospital Administrator **Date**

DHR/MHDDAD
CRITICAL INCIDENT FOLLOWUP REPORT
FOR MEDICAL HOSPITALIZATION

Instructions: Fill in information immediately below the instructions (*Consumer Name through E-Mail of Contact Person*). Type in the information requested after each numbered item. Use complete sentences. Do not answer in partial sentences after each individual question. Obtain review by the designated Senior Executive Manager in your agency. Send the report in the mail within 30 days of the incident date.

Consumer Name:
Date of Critical Incident:
Date of This Report:
Name of State Hospital or Community Provider:
Name of Contact Person for Information about this Report:
Telephone number of contact person:
E-Mail of Contact Person:

1. Describe what led up to the decision to seek medical hospitalization for the consumer. Include information about the consumer's symptoms and what treatment was sought and/or given prior to the admission. If known, list admitting diagnosis to medical hospital.

2. Describe the course of treatment for the consumer while hospitalized. In addition, if you can obtain a copy of the discharge summary, attach a copy.

3. Did the consumer return to your agency's services, and/or was the consumer discharged from your services? If the consumer returned to a different level of services, please explain. If the consumer returned to the agency, please describe how any recommendations from the medical hospital were incorporated in the consumer's services.

4. What is the consumer's status related to the medical issues that resulted in medical hospital admission?

5. Could anything have been done to prevent the consumer's illness that led to hospitalization? What opportunities for improvement have been identified related to this incident? What corrective action is needed or has already been taken?

Report completed by:

_____ _____

Name/Title **Date**

_____ _____

Reviewed by: **Date**

DHR/MHDDAD
CRITICAL INCIDENT FOLLOWUP REPORT
FOR CONSUMER INJURY REQUIRING TREATMENT BEYOND FIRST AID

Instructions: Fill in information immediately below the instructions (*Consumer Name through E-Mail of Contact Person*). Type in the information requested after each numbered item. Use complete sentences. Do not answer in partial sentences after each individual question. Obtain review by the designated Senior Executive Manager in your agency. Send the report in the mail within 30 days of incident date.

Consumer Name:
Date of Critical Incident:
Date of This Report:
Name of State Hospital or Community Provider:
Name of Contact Person for Information about this Report:
Telephone number of contact person:
E-Mail of Contact Person:

1. What level of observation (describe degree of supervision expected) was the consumer on at the time of the incident?

2. What antecedent events occurred?

3. How many staff were present and where were they in relation to the consumer? Address whether or not staff were where they were supposed to be.

4. Where and when did the incident occur? What happened?

5. How did staff respond? Was the response of staff consistent with agency policy & procedures and with the consumers' ISP's/Treatment Plans/Behavior Support Plans?

6. Describe the consumer's injury and how it was treated.

7. Describe what happened after the incident with the consumer.

8. Could/should the incident have been prevented? How? What should be done to prevent recurrence?

9. What opportunities for improvement did you identify? What corrective action is needed or has already been taken?

Report completed by:

_____ _____ _____

Name/Title **Date**

_____ _____ _____

Reviewed by: **Date**

Administrative Review form

Consumer Name:	Incident #:	Incident date:
Reviewer Name/title:	Region:	

☐ Based on my review, the following additional information or corrections are required:

_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Based on my review, the investigation/report is complete.

_____ _____
Reviewer Signature Date

Request for Extension

Instructions: Complete the form below (please type the information) and email or fax to the Investigations Section. For state hospitals, the request must be approved by the Regional Hospital Administrator. For contracted community providers, the request must be approved by a responsible executive manager.

Date of Request:

Incident Report #:

Consumer(s) Name:

Date of Incident:

Provider Agency Name:

Reason(s) for the request:

Expected completion date:

_____
Name/title of requesting party

_____
Date

_____
Approved by Name/title:

_____
Date

Typed signature verifies review/approval of request

Corrective Action Plan Format

Provider Name: _____ **Date of Plan:** _____

Consumer Name: _____ **Incident #:** _____ **Date of Incident:** _____

Issue	Identified Problem	Corrective Steps	Target Date	Responsible Person

Person Responsible for CAP: _____

Contact #: _____

Managerial Review of Corrective Action Plan

State Hospital/Community Provider Name _____
Title _____ **Date:** _____

Typed signature verifies review/approval of Corrective Action Plan